STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	C 07/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION CAPITOL	1225 WALKER ROAD DOVER, DE 19904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility July 17, 2017 and July 19, 2017. The deficiencies contained in this report are based on interviews, and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred fifteen (115). The survey sample totaled four (4). Abbreviations/Definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; MDS - Minimum Data Set-standardized assessment forms used in nursing homes; CNA - Certified Nurse's Aide; UM - Unit Manager; ADL - Activities of Daily Living, such as bathing and dressing; aspiration-the act of taking foreign matter into the respiratory system ; eMAR - Electronic Medication Administration Record; calcified - accumulation of calcium salts in body tissue; Cognition-thinking, memory; Cognitively Impaired - mental decline including losing the ability to understand, talk or write; Congestive Heart Failure - the heart's inability to pump an adequate supply of blood; Continent - voluntary control over bladder and bowel discharge; Dementia - brain disorder with memory loss, poor judgement, personality changes and	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/10/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 disorientation; Diabetes-high sugar levels in the blood; endoscopy - specialized instrument used to visualize and operate on the internal organs and vessels of the body; Incontinence - loss of control of bladder and/or bowel function; Mechanically Altered Diet - used for someone who has difficulty swallowing; ml-milliliter; Pneumococcal vaccine - helps to decreases the effects (sickness or death) of a certain type of lung infection; Pneumonia - a lung infection that can make you sick; Chronic Respiratory Failure - ongoing condition due to an inadequate gas exchange by the respiratory system; Void - release of urine from the urinary bladder.	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure	F 225		10/2/17

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F 225	Continued From page 2 body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the	F 225		

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F 225	Continued From page 3 administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews, a clinical record review and a review of other facility documents, it was determined that the facility failed to investigate and report to the State Agency an allegation of abuse/mistreatment reported May 2017 concerning an examination glove that was removed from the stomach of 1 (R1) out of 4 sampled residents while hospitalized. Findings included: R1's clinical record and facility documents revealed the following: Admission face sheet documented an original admission date of April 2009. Quarterly Minimum Data Set (MDS) completed 1/14/17 showed that the resident displayed physical behaviors including but not limited to scratching, pushing, and grabbing 1 to 3 days during the review period. No specific behaviors were documented on the Quarterly MDS completed on 4/8/17. MDS discharge with anticipated return completed on 4/24/17 reflected that R1's cognitive skills for decision making were severely impaired. R1 required extensive assistance and/or total assistance with all activities of daily living such as but not limited to bathing, dressing, toileting, eating and personal hygiene.	F 225	A.) R1 was not negatively impacted by this deficient practice. B All residents who are noted to have a concern in regards to care have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in #1c. C.) The facility will conduct a focus review of all newly received resident/family concerns forms in regards to care concerns. The facility will conduct focused education for all staff employed by Cadia Capitol on policy and procedure for (1) resident/family concerns and reporting/ investigations guidelines, (2) the reporting and investigation of alleged incidents involving abuse, neglect, exploitation, or mistreatment, and (3) timely reporting to the state agency. D.) The Nursing Home Administrator (NHA)/designee will audit all newly received resident/family concerns forms in regards to care concerns and potential allegations of abuse. The audit will be conducted daily until 100% compliance is achieved. Then, the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then, the audits will	

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F 225	Continued From page 4 Progress notes from 4/24/17 showed that R1 was sent out to the hospital due to a fever and after an an xray showed that there was a bowel problem as well. Hospital records from 4/24/17 to 5/6/17 showed the following: R1 was treated for various conditions while at the hospital and had a feeding tube inserted. The records reflected that while doing an endoscopic test the physician observed a foreign body in R1's stomach and removed it on 5/4/17. The foreign body was a compressed exam [examination] glove covered with a dark brown substance as well as other substances. Progress note dated 5/9/17 at 4:21 PM- nurse received a call from R1's responsible party (RP) who was upset that R1 was receiving speech therapy. Resident is on a tube feeding and the doctors at the hospital told him that there was a test done and they found some foreign body, so the resident should continue on having nothing by mouth. RP wants therapy discontinued. Physician made aware. During an interview with the surveyor on 7/17/17 at 11:35 AM, E2 (DON) stated that she had not received any information about the glove from the hospital staff prior to discharge nor when R1 was discharged from the hospital on 5/6/17. E2 became aware when an investigator called from the Division of Long Term Care Residents Protection on June 16, 2017 requesting specific medical records for R1. No facility investigation was initiated at that point. On 7/17/17 at 11:50 AM the surveyor interviewed E3 (LPN-UM). E3 stated that the responsible	F 225	be conducted weekly until 100% compliance is achieved over three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting.	

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F 225	Continued From page 5	F 225		

party called on 5/9/17 but was not specific about the foreign object so E3 wrote the note and did not tell anyone because there was really nothing to tell. There were no hospital records sent on readmission regarding a foreign object/body found and R1 was "doing good."

During an interview with the surveyor on 7/19/17 at 10:15 AM, E1 (NHA) stated that R1's RP called him/her while R1 was still in the hospital and indicated that hospital staff had found and removed an exam glove from R1's stomach. The RP did tell E1 that the glove was calcified and that he/she thought that staff may have forced it down R1's throat. E1 did not document the call but based on the records the call was between 5/4/17 (discovery of the glove) and 5/6/17 when R1 was discharged back to the facility. In addition, E1 further stated that he/she did not start an investigation because he/she was unsure of how to proceed because of the calcification of the glove, meaning it was there for a while. E1 acknowledged that the facility did not receive any information from the hospital and was not aware of any documents sent back regarding the glove on readmission.

The surveyor received the facility's "Incident Investigation Guideline" policy (reformatted March 10, 2017) on 7/19/17 at 10:35 AM and reviewed the document. There were non-reportable incidents that required an investigation with documentation and there were reportable incidents such as but not limited to allegations of staff to resident abuse and injuries of unknown origin that were to be investigated and forwarded to the State Agency within specified timeframes. The facility did not generate a non-reportable event nor a reportable event regarding the RP's

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F 225	Continued From page 6 allegations that staff may have been responsible and did not investigate the reportable occurrence. The above findings were discussed at the exit conferences with E2 [DON] on 7/17/17 at 3:15 PM and again on 7/19/17 with E1 and E2 at approximately 10:55 AM.	F 225		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--	F 280		10/2/17

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F 280	Continued From page 7 (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 280		

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F 280	Continued From page 8 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on a clinical record review and staff interviews, it was determined that the facility failed to make the necessary revisions to the plan of care based on assessed needs and current orders for 1 (R1) out of 4 sampled residents. Findings included: Review of R1's clinical record revealed: R1's physician's orders on admission back to the facility: 5/6/17- Tube feeding at 50 millimeters (mls) per hour until evaluated by the dietician 5/8/17- Diet- nothing by mouth 5/8/17- Tube feeding at 50 mls for 20 hours or until 1000 mls total 5/9/17 through 5/18/17- orders reflected R1 was to only have tube feedings and nothing by mouth. R1's current care plan reviewed on 7/17/17 reflected the following: Problem Area (PA): PA #13c -Potential for aspiration related to mechanically altered diet as indicated for swallowing difficulties with an edit/revision date of 5/15/17 Approach: Diet as ordered with an edit/revision date of	F 280	A.) R1 was not negatively impacted by this deficient practice. B.) All residents who require the use of tube feedings have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in #1c. C.) The facility will conduct a focus review of all requiring tube feedings. The facility will conduct focused education for RNACs, LNACs, and Unit Managers on proper technique for updating residents plan of care related to the residents need for tube feeding. D.) The Director of Nursing/designee will audit all residents who are noted to require the use of tube feedings to ensure proper care plan updates have been completed. The audit will be conducted daily until 100% compliance is achieved. Then, the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then, the audits will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then, another audit will be conducted in one month. If	

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F 280	Continued From page 9 5/18/17 The facility failed to revise the care plan to include the physician's orders listed above. During an interview with the surveyor on 7/17/17 between 12:23 PM and 12:35 PM, E2 (DON) stated that care plans need to be updated and issues that are not applicable need to show resolved or discontinued. It was the responsibility of the Unit Manager to update R1's care plan. During an interview with the surveyor on 7/7/17 at approximately 12:45 PM, E3 (LPN-UM) stated that R1's care plan PA-13c was supposed to be discontinued when R1 returned from the hospital with new orders. E3 stated that he/she would update the care plan. These findings were discussed at the exit conferences with E2 on 7/17/17 at 3:15 PM and again on 7/19/17 with E1 (NHA) and E2 at approximately 10:55 AM.	F 280	100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting.	
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically	F 334		10/2/17

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F 334	Continued From page 10 contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes	F 334		

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F 334	Continued From page 11 documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, it was determined that the facility failed to provide 1 (R2) out of 4 sampled residents and/or R2's responsible party another opportunity to receive education and/or the pneumococcal immunization after the physician indicated that it was contraindicated due to an illness (pneumonia) but could be brought up at a later date. In addition, the facility failed to follow their policy "Residents Pneumococcal Policy" and offer to revaccinate R2 who was at high risk due R2's diagnoses and conditions. Findings included: The facility's "Residents Pneumococcal Policy" with an effective date of 2006 and a revision date of February 2017 reflected the following: -After age 65, vaccinated residents are not "revaccinated" every five years unless the resident is at high risk due to the following diagnoses or conditions including but not limited to diabetes mellitus [high blood sugar], chronic pulmonary disease [difficulty breathing], and chronic cardiovascular [heart] disease. -For residents that are candidates for the vaccine	F 334	A.) R2 potentially was impacted by this deficient practice. B.) All residents who newly admit to the facility and are above age 65 and considered as "high risk" to meet the criteria to receive a pneumococcal vaccine every 5 years as per facility policy have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in #1c. C.) MD for R2 will be consulted in regards to resident's potential need for pneumococcal vaccine and plan of care will be addressed accordingly. The facility will conduct a focus review of all like residents. The facility will conduct focused education for all licensed nursing staff on policy and procedure for pneumococcal vaccination and consent completion. D.) The Director of Nursing (DON)/designee will audit all residents who newly admit to the facility and are above age 65 and considered as "high	

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F 334	Continued From page 12 the facility provides education and the consent form is "notated" that the education was given. -The nurse obtains a physician's order. -The resident's temperature is taken prior to administration of the vaccine and is delayed for resident's with a temperature of 100 degrees Fahrenheit and above or in those with active respiratory infection. -Vaccination administration is recorded in the resident's medical record and on the Medication Administration Record. -The vaccine can be given any time of the year. R2's clinical record was reviewed: Influenza [Flu] Immunization Informed Consent and Pneumovax (Pneumococcal) Vaccine Informed Consent sheet with a date of 10/14/15 reflected: Last Pneumovax vaccine was last done in 2006. Documentation on the sheet showed that the facility physician did not want the vaccine given to R2 at the time "due to a diagnosis of pneumonia, son in agreement." Nursing documented on the sheet that the physician indicated that when R2 was discharged his/her physician could "reapproach" the pneumovax issue. The form included a space for the legal representative and resident to sign both were blank. An Immunization Record sheet for 2015 indicated that according to the physician the vaccine was not indicated "at this time." The electronic medical immunization sheet for R2 showed that the pneumococcal vaccine was refused on 10/14/15 with no other explanation. R2's clinical record reflected that R2 was admitted on 10/14/15 (face sheet) and was not discharged to home in 2015 or 2016 (Progress	F 334	risk" to meet the criteria to receive a pneumococcal vaccine every 5 years. The audit will be conducted daily until 100% compliance is achieved. Then, the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then, the audits will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	C 07/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 334	Continued From page 13 notes). Further review of R2's clinical record revealed the following: Admission face sheet showed that R2 was over 65. Minimum Data Set (a nursing home assessment tool) completed on 6/1/17 showed R2 was moderately cognitively impaired. 6/26/17 progress notes - showed that the resident was sent to the hospital on 6/26/17 for evaluation due to an elevated temperature, cough, and other respiratory symptoms. 6/29/17 progress note - indicated that resident returned from the hospital and had a hospital diagnosis that included but was no limited to pneumonia. Physician order reports for June 2017 showed R2 had diagnoses that included but were not limited to acute and chronic respiratory failure, heart failure, and diabetes mellitus. There was no evidence on the clinical record to show that R1 or the responsible party had been offered the vaccine since his original admission when it was contraindicated due to his acute condition. R2 is at high risk and meets other criteria in the facility's "Residents Pneumococcal Policy" for receiving the vaccine every five years and has not had the pneumococcal vaccine since 2006. During a brief interview with the surveyor on 7/17/17 at approximately 3:00 PM, E2 (DON) stated that he/she was not able to find any evidence that R2 or his/her responsible party had been offered the vaccine since the admission date.	F 334		

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F 334	Continued From page 14 The above findings were discussed at the exit conferences with E2 on 7/17/17 at 3:15 PM and again on 7/19/17 with E1 (NHA) and E2 at approximately 10:55 AM.	F 334		
F 514 SS=B	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and	F 514		10/2/17

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F 514	Continued From page 15 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on a clinical record review and staff interviews, it was determined that the facility failed to consistently document required data on the scheduled toileting flowsheets for 1 (R2) out of 4 sampled residents based on R2's established toileting schedule/plan. Findings included: R2's clinical record reflected the following: Scheduled Toileting Flowsheets with set times each day to check/toilet and/or change R2 May 2017 - on at least 35 out of 156 occasions staff failed to document if R2 voided or not and whether R2 was wet or dry June 2017- on at least 27 out of 155 occasions staff failed to document if R2 voided or not and whether R2 was wet or dry July 2017- on at least 10 out of 34 occasions staff failed to document if R2 voided or not and whether R2 was wet or dry During an interview with the surveyor on 7/17/17 at 1:30 PM, E4 (CNA) stated that R2 was both continent and incontinent at times. R2 had a program to toilet, check and change R1. Staff is suppose to document according to the schedule. The surveyor interviewed E2 (DON) on 7/17/17 at 2:15 PM. E2 stated that R2's flowsheets were supposed to be filled out by staff and were not completed. During an interview with the surveyor on 7/17/17 at 2:25 PM, E3 (LPN-UM) stated that direct care staff are responsible for filling out the scheduled	F 514	A.) R2 was not negatively impacted by this deficient practice. B.) All residents who require the use and implementation of a toileting program have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in #1c. C.) The facility will conduct a focus review of all like residents. The facility will conduct focused education for all Certified Nursing Assistant on the policy and procedure for toileting programs and proper documentation guidelines. D.) The Director of Nursing (DON)/designee will audit all residents who require the use of a toileting program to ensure proper completion. The audit will be conducted daily until 100% compliance is achieved. Then, the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then, the audits will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting.	

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F 514	Continued From page 16 toileting flowsheet routinely. E2 acknowledged that R2's flowsheets shown to her by the surveyor were incomplete. The above findings were discussed at the exit conferences with E2 on 7/17/17 at 3:15 PM and again on 7/19/17 with E1 (NHA) and E2 at approximately 10:55 AM.	F 514		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

FACILITY NAME: Cadia Rehabilitation Capit
July 19, 2017

DATE SURVEY COMPLETED:

	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES (PoC)	COMPLETION DATE
3201 3201.1.0 3201.1.2	**The State Report incorporates by reference and also cites the findings specified in the Federal Report.** An unannounced complaint survey was conducted at this facility July 17, 2017 and July 19, 2017. The deficiencies contained in this report are based on interviews, and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred fifteen (115). The survey sample totaled four (4). **Regulations for Skilled and Intermediate Care Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed July 19, 2017: F225, F280, F334, F514	Our plan of correction is to Cross Reference CMS 2567-L survey completed July 19, 2017, regarding F255, FF280, F334, and F 514.	10/2/17

Provider's Signature Lisa L Hollinger **Title** Administrator **Date** 8/10/17